ANNUAL REPORT

OF THE COMMITTEE

TO MAKE A STUDY OF

PUBLIC AND PRIVATE SERVICES,

PROGRAMS AND FACILITIES

FOR THE AGING IN

SOUTH CAROLINA

APRIL, 1978

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April, 1978

INTRODUCTORY STATEMENT

To The Honorable James B. Edwards, Governor of South Carolina and Members of the South Carolina General Assembly:

Numerous issues concerning the well-being of the older citizens of South Carolina have come to the attention of the Committee since its creation by Concurrent Resolution 1286 on June 17, 1969. Most of these concerns have been addressed by legislation sponsored by the Committee. Current legislative recommendations are outlined in the body of this report and previously enacted legislation is described in Appendix F. As a result of the continued need to study and take action on matters concerning older South Carolinians, the Committee introduced and the General Assembly passed legislation during the early part of the 1978 session making the Committee a permanent study committee.

In addition to continuing study of matters previously brought to the attention of the 1977 General Assembly, the Committee conducted an active interim period of activities which is summarized in this report.

Two primary concerns have received the attention of the Committee during the past year. The first is the need to expand and improve community based services for older citizens. The Committee sponsored a conference in Columbia on November 29 and 30, 1977 to spotlight the need for South Carolina to adopt programs and policies aimed at allowing our older citizens to remain in their homes and communities for as long as possible. The "Thinktime" on Expanding and Improving Community Supportive Services for Older South Carolinians was held in cooperation with the Commission on Aging, the Department of Health and Environmental Con-

trol, the Department of Mental Health, the Department of Social Services and the University of South Carolina School of Public Health and Social Problems Research Institute. The "Thinktime" participants identified actions which need to be taken to bring about increased emphasis on community supportive services. The findings are summarized in the report of the conference which will be distributed by May 1 to the Governor, the General Assembly, relevant State and local agencies, older citizens organizations, service providers, academicians and others interested in providing appropriate and adequate care for our older citizens. This conference resulted in an awareness that not enough is being done to bring about coordination among agencies delivering community supportive services to the elderly. The "Thinktime" also added impetus to a Task Force which had already been appointed by the Committee Chairman to develop a proposal for a pilot project to demonstrate the value of community based services. This proposal should be ready for submission by the end of May and is fully supported by the Governor and the heads of the Commission on Aging, the Department of Health and Environmental Control and the Department of Social Services.

The second primary concern of the Committee relates to the condition of the State Medicaid program. The projected deficit continues to threaten already deficient medical services for our elderly citizens. The Committee's recommendations on the Medicaid program are contained in a letter to the Chairman of the Committee charged with reviewing proposed cuts in the Medicaid program. (See Appendix D) As stipulated in this letter and other presentations of the Committee during the past year which are included in this report, the Committee feels that the State of South Carolina must address the problems caused by its low Medicaid income limitation (Cap) for institutional care. This income limitation, the lowest in the Nation at $335 per month, is causing severe problems for those low to middle income elderly South Carolina citizens who need institutional care but whose incomes fall above the State set income limitation. The Committee has requested $844,000 to raise the income limitation to $435 per month to provide some immediate relief. However, this will not solve the problem. We must also take a long range look at our Medicaid eligibility criteria in an effort to see that adequate medical care is not beyond the reach of those elderly South Carolina citizens who need institutional care but are presently denied assistance because their incomes fall a few dollars above an

arbitrary income limitation. In addition, we need to work toward providing an institutional admissions screening and referral program and an adequate system of community supportive services so that we may assure the appropriate level of care for our older citizens. We must confront the problems of South Carolina's Medicaid program and, after careful study, commit the funding necessary to fulfill our obligation to see that our older citizens are properly and appropriately cared for.

The Committee will continue to study these matters and to work toward programs to benefit our older citizens. With your continued support, we can provide a better life for South Carolina's older citizens.

The Committee would like to recognize the dedicated service of the late George Carlton who served as a member from 1975 to 1977. His active participation contributed significantly to the work of the Committee during these years.

Future areas of study are outlined in the final section of this report. Additional information regarding the Committee's recommendations is available on request.

Respectfully submitted,

/s/ HYMAN RUBIN, *Chairman*
Senator

/s/ PATRICK B. HARRIS
Vice-Chairman
Representative

/s/ T. DEWEY WISE
Senator

/s/ JOHN H. WALLER, JR.
Senator

/s/ EUGENE S. BLEASE
Representative

/s/ H. PARKER EVATT
Representative

/s/ REVERAND JAMES ALEWINE
Gubernatorial Appointee

/s/ MRS. JUNE P. FURMAN
Gubernatorial Appointee

/s/ DR. JULIAN PARRISH
Gubernatorial Appointee

Research and Administrative Director

MRS. SARAH C. SHUPTRINE
S. C. Study Committee on Aging
The State House
Columbia, South Carolina 29201
(803) 758-8601

REPORT ON LEGISLATION RECOMMENDED BY COMMITTEE TO STUDY PUBLIC AND PRIVATE SERVICES, PROGRAMS AND FACILITIES FOR THE AGING
1977 AND 1978 SESSIONS

Description	*House*	*Senate*	*Status*
Five percent increase in retirement benefits for State employees and teachers who retired prior to July, 1972.			Included in 1977 Appropriation Bill.
Establishment of Interagency Council on Transportation.	H. 2604	S. 296	Passed (R. 140)
To provide for homestead tax exemption for surviving spouse 57 years of age or older.	H. 2063	S. 26	Passed (R. 67)
Concurrent Resolution to continue Committee on Aging during 1978 session.		S. 200	Passed
To provide additional funding for residential care facilities.			Included in 1977 Appropriation Bill.
To provide extension of powers of attorney into state of incompetency, if principal so desires in writing.	H. 2330	S. 155	Passed (R. 398)
To allow withdrawal or withholding of life-sustaining equipment on written request of terminally ill person.	H. 2419	S. 197	Tabled Continued
To allow State reimbursement of $10,000 municipal homestead tax exemption.	H. 2468	S. 235	House Ways and Means Senate Finance
To add a representative of the general public to the Hearing Aid Dealers and Fitters Commission within DHEC.	H. 2511	S. 237	Passed (R. 522)

Description	*House*	*Senate*	*Status*
Lowers age from 65 to 60 to qualify for free tuition program on space-available basis.	H. 2981	S. 488	Senate Finance House Ways and Means
To freeze assessment rates on homestead tax exempt property at the 1978 rate. (Aging Committee is supporting raising the exemption to $15,000)	H. 3248	S. 595	House Ways and Means Senate Finance
To continue the Aging Committee as a permanent study committee.	H. 3247	S. 594	Passed (R. 420)
To continue homestead exemption for surviving spouse and to allow such surviving spouse nine months in which to obtain complete fee simple title to the homestead if spouse died intestate; continues exemption for owned dwelling place on leased land.	H. 2318		Passed (R. 498)
To provide for amendments to the hearing aid licensing laws, including the addition of a 30-day trial period.	H. 3788		House Medical. Military, Municipal and Public Affairs.
To provide for the licensure of public, nonprofit and proprietary home health agencies.	H. 3825	S. 878	House Medical, Military, Municipal and Public Affairs Senate Calendar
*To provide $155,000 Title XX matching funds for home health services.			Requesting inclusion in 1978 Appropriation Bill (DHEC)
*To provide $262,000 for Area Agencies on Aging for community based services.			Requesting inclusion in 1978 Appropriation Bill (COA) —$112,000 additional funding approved by Ways and Means.

Description	*House*	*Senate*	*Status*
*To provide $844,000 to raise Medicaid income limitation (Cap) from $335 to $435 per month in order to assist low income elderly citizens with long-term institutional care costs.			Requesting inclusion in 1978 Appropriation Bill (DSS)
*To provide $300,000 for funding of pilot project to demonstrate value of community based services so as to prevent or delay premature or inappropriate institutionalization.			Requesting inclusion in 1978 Appropriation Bill (DHEC)
To provide $10,000 increased funding for Committee on Aging bringing total to $27,261.			Requesting inclusion in 1978 Appropriation Bill (Miscellaneous Section)

* Requested in testimony before Budget and Control Board on October 12, 1977 by Senator Hyman Rubin, Chairman, Aging Committee.

MAJOR ACTIVITIES OF THE AGING COMMITTEE DURING 1977 INTERIM PERIOD

U. S. HOUSE AND SOUTH CAROLINA AGING COMMITMITTEES HOLD JOINT HEARING IN COLUMBIA—October 8, 1977

The U. S. House Select Committee on Aging and the South Carolina Study Committee on Aging held a joint hearing on problems of older South Carolinians at the State House in Columbia. The hearing was chaired by Senator Hyman Rubin, Chairman of the S. C. Study Committee on Aging. Congressman Claude Pepper, Chairman of the U. S. House Select Committee on Aging was unable to attend due to illness. Over 200 persons attended the hearing and testimony was received from 18 persons. Senator Ernest Hollings, Congressmen Mendel Davis, Kenneth Holland and Floyd Spence were also present. Transcripts of the hearing will be available shortly and will be distributed to the Governor and members of the General Assembly on receipt. (See Appendix A)

SENATOR HYMAN RUBIN, CHAIRMAN OF THE S. C. STUDY COMMITTEE ON AGING PRESENTS TESTIMONY TO THE BUDGET AND CONTROL BOARD REGARDING NEEDS OF SOUTH CAROLINA'S OLDER CITIZENS—October 12, 1977

Senator Hyman Rubin testified before the Budget and Control Board regarding the priority needs of the older citizens of South Carolina as seen by the Study Committee on Aging. These priority needs resulted from testimony received in public hearings and through study by the Committee. (See Appendix B)

MRS. SARAH SHUPTRINE, RESEARCH AND ADMINISTRATIVE DIRECTOR, S. C. STUDY COMMITTEE ON AGING PRESENTS TESTIMONY AT HEW HEARINGS HELD IN COLUMBIA ON NATIONAL HEALTH INSURANCE—October 20, 1977

Mrs. Sarah Shuptrine presented testimony regarding the needs of older South Carolinians and how this might affect the Administration's planning of National Health Insurance. The problems caused by South Carolina's low Medicaid income limitation (Cap) and the need to expand alternatives to institutionalization were the main topics of her testimony. (See Appendix C)

APPOINTMENT OF TASK FORCE TO DEVELOP PILOT PROJECT TO DEMONSTRATE VALUE OF COMMUNITY SUPPORTIVE SERVICES—October 27, 1977

Senator Hyman Rubin, Chairman of the S. C. Study Committee on Aging appointed a task force to develop plans for a pilot project in South Carolina to demonstrate the value of community supportive services. This task force is composed of agency representatives, providers of services, University of South Carolina representatives and representatives from the Governor's Office and the General Assembly. The pilot project is supported by the heads of the Department of Health and Environmental Control, the Department of Mental Health, the Department of Social Services, and the Commission on Aging, the Governor and members of older citizens organizations around the State. The proposal should be ready for submission by the end of May. Senator Rubin included the pilot project in his presentation to the Budget and Control Board on October 12, 1977. Matching funds will be requested to fund this project over a three-year period.

STUDY COMMITTEE ON AGING SPONSORS A "THINK-TIME" ON EXPANDING AND IMPROVING COMMUNITY SUPPORTIVE SERVICES FOR OLDER SOUTH CAROLINIANS—November 29 and 30, 1977

The S. C. Study Committee on Aging sponsored a conference in Columbia on November 29 and 30 to spotlight the need for expanding and improving community supportive services. The "Thinktime" on Expanding and Improving Community Supportive Services for Older South Carolinians was attended by legislators, agency heads, local agency representatives, academic representatives, older citizens, providers of services, health service planners and representatives from the Governor's staff and the staff of the General Assembly. The "Thinktime" resulted in identification of policy directions which need to be taken and also in an atmosphere of cooperation in attempting to work toward the goal of allowing our older citizens to remain in their own homes and communities for as long as possible. The report of the "Thinktime" will be published by May 1, 1978 and copies will be distributed to the Governor and members of the General Assembly.

STUDY COMMITTEE ON AGING HOLDS A PUBLIC HEARING IN COLUMBIA—December 6, 1977

The S. C. Study Committee on Aging held a public hearing in Columbia on December 6, 1977 on problems of older citizens. Testimony was received from 15 people. Suggestions for State action were made regarding the need to raise the Medicaid income limitation (Cap), the need to expand community supportive services, support for implementation of the Uniform Probate Code in South Carolina, the need for more revenue sharing funds to be spent on programs for older citizens, the need for additional property tax relief for older citizens, the need to increase the income tax exemption for retired persons, the desire for passage of the "Death With Dignity" legislation filed by the Committee during the 1977 session, the need for passage of generic drug substitution legislation, the desire for passage of legislation filed by the Committee during the 1977 session to add consumer representation to the Hearing Aid Dealers and Fitters Commission, the need to add consumer representatives to all board and commissions, the need for more outreach services and various other proposals. Senator Rubin's testimony before the Budget and Control Board on October 12, 1977 was endorsed by the

Commission on Aging, the S. C. Legislative Committee of the NRTA-AARP, the S. C. Retired Educators Association, the S. C. Legislative Committee of NARFE and the S. C. Federation of Older Americans.

GOVERNOR JAMES B. EDWARDS CITES THE NEED TO EXPAND HOME BASED SERVICES IN HIS STATE OF THE STATE ADDRESS—January 24, 1978

Senator Rubin met with Governor James B. Edwards on December 21, 1977 to discuss with him the need to expand community supportive services. Governor Edwards included the following remarks in his State of the State Address on January 24, 1978:

> I have concluded that we must redirect resources to the elderly that will aid them in maintaining their independence through services delivered to their homes, such as home-based health, adult day care, transportation, and meals on wheels. These services make sense not only in providing dignity to the elderly but as an alternative to long costly stays in nursing homes.

In addition to his State of the State remarks, Governor Edwards has demonstrated his support for the pilot project described above.

STUDY COMMITTEE ON AGING RESPONDS TO PROPOSED RECOMMENDATIONS FOR CUTTING THE COSTS OF THE MEDICAID PROGRAM—January 3, 1978

The S. C. Study Committee on Aging filed a letter with the Chairman of the Committee to review proposed Medicaid program cuts stating the Committee's concern with many of the recommendations. (See Appendix D)

SENATOR HYMAN RUBIN, CHAIRMAN OF THE S. C. STUDY COMMITTEE ON AGING PRESENTS TESTIMONY BEFORE THE S. C. CONGRESSIONAL DELEGATION—January 23, 1978

Senator Hyman Rubin presented testimony at the annual hearing of the S. C. Congressional Delegation on January 23 at the State House. He asked for the Delegation's support of congressional efforts to expand alternatives to institutionalization. Senator Rubin cited the recent General Accounting Office Report which states the following:

> Until older people become greatly or extremely impaired, the cost of nursing home care exceeds the cost of home care including the value of the general support services provided by family and friends.

Senator Rubin also told the Delegation of the plight of low to middle-income older South Carolinians who are unable to receive medical assistance through the State Medicaid Program because their incomes fall slightly above the State income limitation (Cap) of $335 per month. He spoke in favor of the elimination of mandatory retirement laws and thanked the Delegation for its support of the legislation which bans mandatory retirement prior to age 70. (See Appendix E)

AREAS FOR FUTURE STUDY AND RECOMMENDATION

1. Pre-retirement educational program for State employees;
2. Generic substitution of drugs;
3. State Medicaid Program (projected deficit, eligibility standards, alternatives to institutionalization);
4. Inclusion of eyeglasses, hearing aids and dentures in Medicaid Program on ability-to-pay basis;
5. Inclusion of consumer representation on all boards and commission which deliver services to older citizens;
6. Expansion, coordination and improvement of community supportive services for older citizens;
7. Multi-service senior centers;
8. Present retirement benefits, including continued cost-of-living increases for State retirees;
9. State mandatory retirement laws; and
10. Inclusion of home health benefits as a mandatory service under State insurance laws;

Appendix A

OPENING STATEMENT BY
CONGRESSMAN CLAUDE PEPPER, CHAIRMAN,
U. S. HOUSE SELECT COMMITTEE ON AGING
"Impact of Federal Legislation on the Elderly"
Columbia, South Carolina
October 8, 1977

It is a distinct pleasure to convene this unique and important meeting of the Select Committee on Aging of the U. S. Congress and the South Carolina Joint Study Committee on Aging.

I want to extend special thanks to my distinguished Co-chairman, Senator Hyman Rubin, the members of the Study Committee and your very capable and energetic Administrative Assistant, Mrs. Sarah Shuptrine for the invitation to come to South Carolina and learn first-hand the needs and aspirations of your senior citizens.

Let me express my appreciation too, to my colleagues from the Congress who have come to take part in this historic meeting.

This is an historic occasion. I can't recall many times in the past when a joint venture of this kind has been undertaken. But we are not here to talk about history. We have come to learn about the present—and the future—of the 300,000 elderly people of South Carolina.

The timing is crucial.

There has never been a greater opportunity to improve the lives of the elderly than at the present.

We have a sympathetic Congress and an open-minded Administration that is ready to experiment with new ways to solve old problems.

Governments at every level have taken bold initiatives in the field of aging.

More funds are being appropriated for the elderly—a half billion dollars for the Older Americans Act programs alone for fiscal 1978, over $70 million more than last year.

We have an established aging "network", which reaches into the towns and counties of every State and is run by local residents. The President, the Governors and Legislators have discovered that the elderly are a powerful force—an army of 23 million men and women who refuse to be ignored, who refuse to be slighted, and who refuse to be tossed away like yesterday's newspaper.

I am convinced we are on the threshold of great things for senior citizens. But the goals we want won't come to us—we have to fight for them.

We will have to fight to see that the elderly get a fair shake in a national health insurance plan. To do that, we're going to have to preach a little gospel to our friends in the Administration and the Congress. We're going to tell them we want a health program that keeps our older people out of nursing homes. We want more home health care, and day health care, and better outpatient clinics. We want national health insurance to pay for eyeglasses, hearing aids, and dentures. Our people deserve to be able to see and hear and eat their food properly. These aren't luxuries; they are critical to the well-being of millions and millions of Americans. We also want

national health insurance to cover preventive health care— not just for children, but for the elderly and those in their middle years, as well. The hypertension screening program here in South Carolina is a model of the kinds of programs that can and should be done.

We have to find ways, as I know you are trying, to beef up existing health programs like Medicaid so they don't go broke and so people get services they need. It is a tragedy that over 20 states have been forced to cut back services because of budget deficits. Many people who need care can't get it now because of restrictive requirements— even before further cutbacks are made.

If we are going to take full advantage of this new emphasis on the elderly, we must press for more efficient transportation, in vehicles that are built to accommodate people who have a little trouble getting around sometimes, and with fares that won't empty their pockets.

The new day for the elderly will mean we fight for better Social Security benefits and decent dwellings, for a pension you can live on and a house you can live in.

And we're going to fight to abolish mandatory retirement—that insidious enemy of the elderly—that arbitrary policy that says: "When you reach the magic age of 65 you no longer have anything to contribute to the economy or the country." We want retirement policies that are based on competence, not chronology. My bill, which passed the house two weeks ago 359 to 4 is just the beginning. I'm going to fight to let people work who are able and willing regardless of age, not just to 70 as the bill does as a first step. I'm only 77, but I'd punch anyone in the nose who tells me I can't work.

John Stuart Mill said, "Give a man nothing to do for his country, and he will have no love for it." I say, give an older person nothing to do, and then stand back and watch your society crumble without the talent and experience and wisdom of the elderly.

Once again, it is a real pleasure to be with you. We are anxious to hear your views. We will take them to Washington, and we will act on them.

Appendix B

PRESENTATION TO THE BUDGET AND CONTROL BOARD BY SENATOR HYMAN RUBIN, CHAIRMAN S. C. JOINT STUDY COMMITTEE ON AGING

October 12, 1977

The Joint Study Committee on Aging was established in 1969 for the purpose of performing research and sponsoring legislation dealing with problems of the elderly.

In recent years our older citizens have experienced great difficulties because of limited incomes which have been eroded by the common problem of inflation. We feel that the Committee has rendered great service and has been successful as far as possible in alleviating some of these problems.

Much has been done and much remains to be done on all levels of government to accomplish a position for older people that will enable them to live lives of comfort, security and dignity. While we recognize that all the desirable goals cannot be met in any one year, it is imperative as a moral obligation that we continue to move forward.

To this end, we recommend for the earnest consideration of the Budget and Control Board the following proposals:

(1) *Expansion of the Homestead Tax Exemption Program to Municipalities.* The success of this program, which has been of enormous benefit to older people, is due to the fact that the State rebates the county governments the amount of revenue which is lost to them by granting the homestead tax exemption. It was recognized from the start that local government with its limited sources of income could not provide the homestead exemption in any meaningful way. The State is presently expending approximately $5 million in rebates to the counties. The extension to municipalities would cost an estimated $1,750,000. This would provide significant additional relief to older citizens, and within the boundaries of municipalities there are many whose incomes are particularly low. The Municipal Association of South Carolina fully supports this proposal, and legislation to accomplish it was filed last year by the Committee.

(2) *Improvement of Eligibility Standards for Institutional Care.* One of the most urgent problems confronting us is our low Medicaid Cap with respect to financial assistance for institutional care.

The South Carolina Medicaid Cap is $335 per month—the lowest in the Country. Accordingly, if an older person requires nursing home care and his or her income from Social Security, Veterans Benefits, etc., is more than $335 per month, that older person is not eligible for Medicaid assistance. Through our public hearings and citizens mail, we have heard of many instances of sheer tragedy as a result of this low Cap. In one case presented to us, Medicaid assistance was precluded because of an income of slightly less than $400 per month. Other members of the family—a very respectable family—were wracked by illness and many burdens, and it was impossible for the members of this family to continue to take care of the needy individual. This was a story of a family virtually wrecked by our present limitation. These instances are numerous, with some older persons being declared ineligible for Medicaid benefits by only a few dollars.

The Joint Study Committee on Aging and a special Task Force on Long-Term Care have given considerable study to the present situation and alternative approaches. One alternative used in a number of states is the so-called "spend-down" method whereby the individual needing the nursing care would allocate existing income to the cost and the State and Federal government would make up the difference. We feel that the spend-down method is worthy of further study, but we do not recommend it at the present time because of additional personnel and procedures that would be required and uncertain cost. However, we do recommend that the Governor or the Budget and Control Board create a special task force to give this subject a degree of research and study that is beyond the capacity of the Committee.

For the present, we recommend an increase in the Medicaid Cap of $100. It is estimated that this would cost approximately $844,000 and would generate several times that amount in matching Federal funds.

(3) *Expansion of Home Health Care.* In the area of health services for the elderly, there has been general consensus that home health services should be expanded. This approach has the enormous advantage of allowing older persons to remain at home where they can be with friends, relatives and in a familiar environment. At the same time, this type of service tends to reduce the burden on nursing home capacity and State institutions. In too many instances, elderly persons have been placed in nursing homes and in State institutions like Crafts-Farrow simply because they could not get ade-

quate care at home in a period in which more than one member of a family usually has to work. The thrust of the future must be toward deinstitutionalizing services. Proven benefits in this area have come from the programs of the Department of Health and Environmental Control and other home-based care programs operated through the Commission on Aging and the Department of Social Services. Much more could be done with additional funds.

An appropriation of $155,000 for home health care services is requested to provide 30% Title XX matching funds for general provision of these services statewide, bringing in an additional $362,711 in Federal funding for a total of $517,711 for provision of home health services.

We would also like to recommend an additional appropriation of $300,000 for a special pilot program which in cooperation with local and State agencies and citizen efforts could demonstrate the effects of adequate home health services and other home-based services. An alternative to appropriating additional funding would be to have the Department of Social Services, the Department of Health and Environmental Control and the Commission on Aging work together to obtain an 1115 waiver from the Department of Health, Education and Welfare to divert funding which is presently designated for institutional care for the purpose of funding such a pilot project. Assuming proof of performance, this expansion of alternative services could ultimately cost the State upward of an additional $1.5 million to cover the entire State. At present, we are only requesting $300,000, but are mindful of the fact that later, more complete development could provide incalculable benefits. A recent study of the Department of Health, Education and Welfare stated that between 15% to 25% of persons in nursing homes could be taken care of in another setting. Other estimates have gone as high as 40%. Screening of nursing home admissions to provide for the proper level of care is an important objective and should be included as a part of the pilot project.

(4) *Increased Allocation for Area Agencies on Aging.* For some years, the Commission on Aging has been requesting an additional $250,000 to support its Area Agencies activities. The ten existing Area Agencies now receive $238,000 in State funding. An additional $262,000, bringing the total to $500,000, would proportionately increase Federal funds available and would enable local areas to do a far better job of servicing older people through such programs as Meals On Wheels, congregate meals, transportation,

recreational and chore services. We feel that this is a meritorious objective by the Commission on Aging, and our Committee is supportive of the Commission's request for additional funding for this purpose.

(5) *Establishment of a Pre-Retirement Educational Program Within State Government.* The Commission on Aging has requested a modest sum of $30,000 to be allocated for a pre-retirement educational program. As you well know, many of our citizens are retiring at ages which leave them with many years of potential usefulness and happiness. It is self-evident that some are mentally and emotionally prepared for retirement, others need assistance and guidance. To this end, some of our major private businesses have, as a public service, set up pre-retirement programs which have been highly praised. We believe that such a program should be established for State employees under the direction of the Personnel Division. This Division will accept the responsibility for coordination if funding is made available. There are many experts who would be willing to offer their expertise in preparing and implementing such a program and would do so without compensation. Such a program would draw heavily upon the voluntary input of college teachers, physicians, psychologists and other professionals. Our Committee feels that with this small appropriation, much could be accomplished and we give our full support to this proposal.

We recognize the major burdens upon this honorable body in attempting to set priorities under the pressure of so many demands for deserving causes. We also have the conviction that you share a compassion for the special difficulties of our older citizens.

We would appreciate your careful consideration of the proposals contained in this presentation.

Appendix C

STATEMENT BY MRS. SARAH C. SHUPTRINE BEFORE HEW HEARINGS HELD IN COLUMBIA, SOUTH CAROLINA ON NATIONAL HEALTH INSURANCE—OCTOBER 20, 1977

The concern which I bring to you today is shared by the "middle income" older citizens in our Country who are not fortunate enough to live in a state which provides for financial assistance in the event of long-term illness. There are 22 states, and South Carolina is one

of those states, which do not provide assistance through a medically needy or spend down provision in their Medicaid programs.

South Carolina's older citizens suffer from an inadequate health care program. The major problem stems from the state's Medicaid Cap which is set at $335 per month—the lowest in the Nation. If an older person's income exceeds that amount, they are denied financial assistance for institutional care. It is obvious that many older citizens with an income level exceeding South Carolina's $335 Medicaid Cap would be and are unable to meet the high cost of institutional care. The highest federally allowed Cap is $534 per month, well below the cost of skilled nursing care.

Medicare benefits, as you know, eventually expire for chronically ill older persons. When this occurs, those persons who can afford to pay for their own medical care and those who fall within the eligibility criteria of a particular state's Medicaid program have the assurance that their medical needs will continue to be met. But, in the 22 states which do not have medically needy provisions, the older citizens who fall somewhere in between these two groups often find adequate health care beyond their reach.

At the present time, many states are suffering from tremendous budget deficits in their Medicaid programs. Instead of expanding and improving our present coverage, we are discussing cuts. Most states are not in the position to provide adequate health coverage and often the victims of this dilemma are those older citizens who cannot meet the costs of adequate care, but whose incomes prohibit them from obtaining assistance through the Medicaid program.

Much needs to be done to improve our medical assistance and health delivery programs. More emphasis needs to be placed on providing the proper level of medical care, through assessment mechanisms which follow through with provision of services, whether home based or institutonal. The institutional bias in the Medicaid and Medicare programs must be reversed. Our Committee recently held a joint hearing in Columbia with the U. S. House Select Committee on Aging and we were dismayed to learn that 70% of the Medicaid money expended on medical care for persons 65 and over is spent on intermediate and skilled care. Less than 1% is spent in the area of home health care. The Medicare program is limited in scope to skilled care and includes obstacles which force us to spend our funding on institutional care rather than home health care which can delay the need for institutionalization and costs less per unit of service. Assistance with the purchase of hearing aids, eyeglasses and dentures is

greatly needed by older persons (we will extract their teeth, but won't replace them), but these options under the Medicaid program are presently left to the states, most of which are unable to afford them.

Our medical assistance program should include flexibility to prohibit the denial of medical assistance simply because an older person's income level exceeds an arbitrary state Medicaid Cap. Our older citizens should be allowed the dignity of contributing what income they may receive toward their medical care and be assured that the remainder of the cost will be met by governmental resources. Our Committee has received testimony in public hearings and otherwise regarding the plight of those older people who are suffering from our present policy. I would like to quote from a letter we received from an elderly lady in which she describes her fear of needing nursing home care and not being able to afford it:

> ". . . If I become permanently disabled there is no one to help me in a monetary way. One of my eyes has been removed . . . and the other is gradually becoming worse and worse. There is a possibility of total blindness. I try not to think about this, but in my subconscious it is ever present. When I think of these things—no place to go, no one to care for me, no money to pay the exorbitant nursing home bills—frankly I become terrified. Without a sense of security life has no meaning."

She does not want charity. She simply wants to pay what she can toward her medical costs and be assured that the state and/or federal government will assist her with the remainder. Without this assurance, she, like many other older citizens, continues to live in fear of what will happen to her.

We do not necessarily have to wait for a National Health Insurance Plan to implement improvements. Relief could come as a result of reform of the present Medicaid program. For example, in a public hearing held by our Committee several weeks ago, it was suggested that the equalization of the Medicaid program could be accomplished by the federal government paying a greater share in those 22 states which do not have a medically needy program. The greater share would only be paid until the state could adjust its budget to implement the program.

At this point in time, equality of coverage does not seem possible without the immediate assistance of the federal government.

We will appreciate your giving careful consideration to these recommendations.

Thank you for the opportunity of appearing before you today.

Appendix D

January 3, 1978

Honorable Frank L. Roddey, Chairman
Nursing Home Study Committee
The State House
Columbia, South Carolina

Dear Senator Roddey:

Thank you for the opportunity to respond to the proposed cuts in the Medicaid program.

It is the feeling of the Study Committee on Aging that the medical assistance program for the elderly in South Carolina is inadequate at present and we are, therefore, most concerned with the possibility of cutbacks.

The following observations are outlined for the consideration of your Committee:

Option 1: As you may know, our Committee has been advocating that a thorough study be conducted to ascertain whether spend down criteria could be adopted in South Carolina. Such a recommendation was presented to the Budget and Control Board on October 12, 1977, a copy of which is attached. We have become aware of many cases in which much suffering has been endured by older citizens and their families because of their inability to qualify for medical assistance under the South Carolina Medicaid program. Most of this suffering is the result of the low South Carolina Medicaid cap of $335 per month. However, under Federal regulations, the highest allowed cap is $534 per month and it is obvious that a person with an income of $540 per month, although unable to qualify for assistance, could not afford the high cost of skilled nursing home care. At present, there are 22 states, including South Carolina, which do not have medically needy or spend down provisions as a part of their Medicaid programs. The older people in these 22 states whose income falls above the Medicaid cap cannot qualify for any medical assistance to meet the cost of nursing home care.

Our Committee received testimony on December 6, 1977 at a public hearing held by the Committee at the State House. Several witnesses testified to the need to find a solution to the dilemma faced by our middle-income elderly South Carolinians with respect to the Medicaid

cap. The minutes of this hearing are enclosed. In one case, a lifelong public servant of our State has been denied medical assistance because his income exceeds the S. C. Medicaid cap, although this same income falls $216 per month short of meeting the cost of his nursing home care. His wife testified:

> "During the first few years of our nearly forty years of marriage, our medical expenses were more than our total income. We were younger then and believed that with hard work we could recoup, and we did manage to do so. But at our age now, recouping is out of the question. Sometimes mere existence seems beyond our means. Our working years and salaries were largely in a different era, and we now find ourselves in the difficult (if not downright degrading) position of being unable (no matter how willing or unwilling) to receive public welfare assistance and unable to stretch our income and savings to cover even current medical costs."

In another case, a daughter, who has no legal responsibility but feels a moral responsibility, is left with less than $175 per month to live on after paying the difference between her mother's income and the cost of her mother's nursing home care.

Just last week we learned of an incident in which a nursing home patient in Sumter is subject to discharge simply because his last Social Security increase put him 1¢ above the South Carolina Medicaid cap. In another case, a patient is 13¢ above the cap and has been denied assistance. This is a deplorable situation.

Under the spend down concept, South Carolina could adopt its own eligibility standards. Such determination of eligibility criteria would have to be given careful study to ascertain its effect on current recipients of services. The concept of spend down seems to be one way in which our State could provide adequate health care assistance for our middle-income elderly citizens who have given so much of themselves over the years to serving their communities and State and who now often find adequate health care beyond their reach. For this reason, we feel that a very careful assessment should be made to determine if spend down would provide the relief needed without causing serious problems of administration and without causing hardship for the present recipients. It is interesting to note that available studies reveal that only a small percentage of those eligible to spend down actually take advantage of the provision.

Option 5: Striving for cost containment through limitation of nursing home beds is a serious step for a State which maintains a

nursing home occupancy rate of approximately 97%. Such a limitation could possibly result in a serious shortage of beds and would impact heavily on our elderly population in need of skilled nursing care. (Under present Federal regulations, it would seem that the only way to limit the beds would be through the State's certificate of need process.) However, while we are very concerned about the negative effects of limiting the number of beds, we are also cognizant of the drain on our funding resources caused by the ever increasing cost of institutional care, making it difficult to expand alternative community based services to reduce the need for institutional care.

It is the feeling of our Committee that if any proposal is adopted to limit the beds that it must be accompanied by a financial commitment to improve and expand alternative services. It should also include the establishment of an effective screening and referral system so that we do not inappropriately place older people in nursing homes. (A very effective screening and referral system is operating in Virginia and we have supplied material regarding the system to Dr. Holmes.) We feel that an effective screening and referral system would be a viable cost effective alternative, but it would be effective only with an adequate system of alternative services in the community. In this manner, only those most in need of skilled nursing home care would be placed in nursing homes while those who could be taken care of in the community could be assisted with alternative services such as home health care, homemaker, transportation and nutritional services.

Option 6: If the State continues to pay for Supplemental Medical Insurance, and we believe it should and agree with the Department of Social Services recommendation that it be continued, we would question the wisdom and the legality of not paying the co-payment and deductibles.

Option 8: The Committee would be opposed to any co-payment for ICF care. The option paper states: "It is unlikely that establishment of a co-payment would decrease utilization, but it would generate some additional revenues." We do not feel that the .1% estimated savings ($18,050) justifies the problems which could be caused by the assessment of a co-payment for ICF care and agree that it is unlikely that it would decrease utilization. Another question is whether or not it would cost more to impose the co-payment than it is projected to save.

We would agree with the Department of Social Services that there be no assessment of a co-payment for home health services. Since

home health is a mandatory service, it would seem that a co-payment would not be allowed under the regulations.

Option 9: The Committee would be opposed to any further cost containment measures with regard to prescription drugs. We expressed our concern last year with the assessment of a 50¢ co-payment on prescription drugs. The first six months of the co-payment program have not produced impressive results with a decrease in the number of prescriptions per client per month of only .2 prescriptions. The overall cost of the drug program was not reduced. We feel that further evidence is necessary to demonstrate the cost effectiveness of the co-payment program. Any action to further burden older citizens who require prescription drugs would be highly undesirable. Furthermore, limitations on prescribed drug treatment could lead to the need for more costly health care treatment.

Option 11: The limitation of inpatient hospital care to ten days per fiscal year would seem to be a questionable procedure. It would seem more appropriate to limit the days per hospital admission. Since the average hospital stay is 7.2 days, an 8-10 day limit per hospital admission would seem to be a better approach with an appeal to the utilization review team for a longer stay, e.g., 15 days, if deemed necessary, with provisions for an absolute limit. (It is our information that any limit on hospital days cannot be imposed without advance notice to Medicaid clients.)

Option 13: The completion of the Medicaid Management Information System should be given high priority.

Option 14A: All possible efforts should be made to adequately fund the Medicaid program to insure the continuance of medical assistance services to older citizens.

Option 14B: Fully comprehending this option and its implications is difficult. It does seem rather questionable to disallow Medicaid coverage for prescription drugs and view it as patient participation. The Committee is, as stated above, opposed to further limitations on the prescription drug program.

Option 14C: Requiring all Medicaid eligibles requesting long-term care to conform with Title XVIII requirements for admission would be forcing a three-day hospital stay on all persons desiring admission to a nursing home and would cause problems of unnecessary hospitalization. Physician and PSRO approval of such hospitalization could also present serious problems. In addition, how could you guarantee that a nursing home bed would be available

at the end of a three-day hospital stay, possibly resulting in a more expensive extended stay. There is also no guarantee that the hospital stay or the resulting long-term care would be a covered service under the Medicare program. We feel that this option should be studied very carefully giving attention to all of the questions raised above. It would seem more desirable to design an effective community screening program to assure appropriate placement.

Option 14D: The Committee would be opposed to limiting skilled nursing coverage to 60 or 180 days.

Option 14E: The Committee would agree with the recommendation of the Department of Social Services to drop this option from further consideration. Reducing long-term care expenditures in proportion to the people served would not be a workable option.

Option 14G: Elimination of some optional services would not be as serious as others, but it is felt that elimination of emergency dental services, prescribed drugs and, in particular, intermediate care services would be extremely detrimental to the elderly. The Committee would be opposed to elimination of these services.

Option 14I: For many of the reasons stated in our discussion of Option 5, any action to limit beds will need to be approached very cautiously and must be accompanied by a financial commitment to expand and improve alternatives to institutionalization. The thrust of the future must be toward deinstitutionalization. This principle is set forth in Section 12 of Act 214 of 1977. We also question the legality of a moratorium and would recommend close study of revision of our certificate of need program as an alternative to the imposition of a moratorium.

As you may already know, our Committee has recommended an increase in the Medicaid cap from $335 to $435. This increase is needed to alleviate some of the suffering outlined in our discussion of Option 1. The projected cost would be $844,000 for fiscal 1979. Further information is available on request.

This letter represents our present concerns. We hope that you will keep the Committee advised of developments in this area.

We would like to make one additional recommendation which has not been mentioned as an option and that is that the State of South Carolina, alone or in conjunction with other states, appeal to the Federal government to bear more of the cost of the Medicaid program. While our Federal match has been decreasing, our costs have

been increasing and we do not feel that it was the intention of Congress that the Medicaid program begin a decline after years of providing needed services to the Nation's poor and disadvantaged people.

We hope that you will contact us if you desire further information on the issues raised in this letter.

Sincerely,

Hyman Rubin

Enclosures

Appendix E

TESTIMONY OF SENATOR HYMAN RUBIN, CHAIRMAN, S. C. JOINT STUDY COMMITTEE ON AGING BEFORE THE S. C. CONGRESSIONAL DELEGATION HEARING HELD IN COLUMBIA ON JANUARY 23, 1978

We were indeed fortunate to have had several of you present for a joint hearing held in Columbia in October by the U. S. House Select Committee on Aging, chaired by Congressman Claude Pepper and the South Carolina Joint Study Committee on Aging, on which I serve as Chairman.

We appreciate this opportunity of appearing before you today to present our views on the needs of South Carolina's older citizens.

There are several subjects which we would like to present to you today.

The first concerns medical care for the elderly in South Carolina. The Medicaid program as administered in South Carolina is not adequately serving our needy older citizens, and, as you know, Medicare covers only a portion of their medical costs. South Carolina along with some 20 other states is experiencing severe budgeting problems with regard to the Medicaid program and proposed cutbacks are threatening to curtail already inadequate services.

We would like to call your attention to some examples of the inadequacy of services which have resulted from a lack of funding and present Federal regulations.

At the present time, the South Carolina Medicaid program provides assistance for skilled nursing home care *only* for those older citizens whose income falls below our State income limitation of $335 per month. Through public hearings and otherwise, our Joint Study Committee on Aging has become aware of many older South Carolinians whose incomes exceed $335 per month and who require skilled nursing home care but cannot afford it. And, under the Fed-

eral Medicaid regulations which are opted for by the State of South Carolina, these low to middle-income elderly citizens could divest themselves of everything they own and still not be eligible for medical assistance if their income remains above this $335 income level. We know of cases which are denied because of an excess income of only pennies.

In 1976, Congress passed a bill to prohibit some Medicaid recipients from becoming disqualified because of increased Social Security or Veterans benefits, but this legislation did not include protection for institutional recipients of Medicaid benefits. As a result, when Social Security or other Federal benefits are increased, we are placed in the position of either raising our income limitation or discharging institutional patients who have become disqualified due to such benefit increases.

The State of South Carolina, under present Federal Medicaid regulations, has instituted a co-payment program for prescription drugs. Also, South Carolina opts not to provide coverage for dentures, eyeglasses or hearing aids which many of our elderly citizens desperately need and cannot afford.

Although the South Carolina Medicaid program represents less than three percent of State appropriated funds, it is currently embroiled in a crisis situation. We are told that the State cannot afford to raise the income limitation. We are also told that the State cannot afford to cover the cost of dentures, eyeglasses and hearing aids or to discontinue its co-payment prescription drug program. We, therefore, have continued to be unable to assist many of our older citizens who find themselves denied assistance through a program paid for by their own taxes.

Since South Carolina began to participate in the Medicaid program in 1968, the Federal share of the program has been decreasing while our costs have been increasing due to many factors, including inflation and increased eligibles. A larger Federal share could provide relief.

We also feel that we need to turn our attention and efforts, both on the national and State level, toward providing more and improved community supportive services which will reduce the need for the higher priced skilled nursing home care. Our Committee, since 1975, has been advocating the expansion and improvement of such services as home health care, homemaker, adult day care, nutrition and transportation—services which will allow our older citizens to remain in

their homes and communities with dignity for as long as possible. The U. S. Senate Special Committee on Aging and the U. S. House Select Committee on Aging have led Congressional efforts to expand these services. A "Thinktime on Expanding Community Supportive Services for Older South Carolinians" was held in Columbia in November and tremendous support was demonstrated at this conference for expansion of community supportive services.

We also feel that community long-term care centers would go a long way toward coordinating these services to make them even more cost effective.

A General Accounting Office Report just published states: "Until older people become greatly or extremely impaired, the cost of nursing home care exceeds the cost of home care including the value of the general support services provided by family and friends." The GAO Report also cites costs for eliminating Medicare restrictions with regard to expansion of home health benefits. H. R. 1116, introduced by Congressman Claude Pepper and 75 co-sponsors seeks to remove these restrictions and we urge your support for this legislation and other legislation which allows for expansion of community supportive services.

The second subject which we would like to comment on is mandatory retirement. We are pleased that both houses of Congress have passed bills dealing with the abolition of pre-70 mandatory retirement. We are opposed to the concept of mandatory retirement and fully support the House version which provides for no exemptions. We appeal to you to support prompt action by the conference committee dealing with this first step toward removing the discrimination of mandatory retirement policies.

We would like to take this opportunity to commend you for passing timely legislation to provide needed fuel assistance relief for the needy. This will be especially helpful to our needy elderly citizens for whom the escalating cost of fuel presents a severe burden.

Our Committee will continue to study the problems of our older South Carolinans and will attempt to deal with those problems on the State level. Your continued assistance, interest and support in Congress will be deeply appreciated.

Appendix F

SUMMARY OF LEGISLATION AND RECOMMENDATIONS PREVIOUSLY RECOMMENDED BY THE STUDY COMMITTEE ON AGING WHICH HAVE BEEN IMPLEMENTED

Homestead Tax Exemption

Homeowners who are 65 or older and have resided in the state for at least one year receive the benefits of a homestead tax exemption which provides that the first $10,000 of the fair market value of the dwelling place shall be exempt from county, school and special assessment real estate property taxes. Counties are reimbursed by the state for losses they incur by reason of granting the exemption. Annual reapplication can be made by mail.

Regulation of Nursing Homes

Nursing homes at all levels of care are strickly regulated and inspected by designated state agencies. In addition, the Governor's staff includes Nursing Home Ombudsmen who receive complaints or reports concerning patient care and who investigate and seek to resolve any problems that may appear. Skilled nursing homes, intermediate care facilities and residential care facilities are now required to provide an item-by-item billing of all charges for all services to the patient or person paying the bill, on request.

Cost-of-living Increases in Retirement Benefits

Teachers, state employees and other public workers covered by the South Carolina Retirement System receive automatic increases in benefits when cost-of-living rises (not to exceed four percent).

Fitting and Selling of Hearing Aids Regulated

South Carolina statutes govern the licensing of persons who fit and sell hearing aids, and regulate the manner in which they conduct their business.

Establishment of State Housing Authority

A State Housing Authority has been established. Its purpose, among others, is to encourage the growth of specialized housing for the elderly.

Tax Exemption for Nonprofit Housing for the Elderly

Private, nonprofit organizations are exempt from real estate taxes on property used as specialized housing for the elderly.

State Agency on Aging Given Commission Status

The Interagency Council on Aging has been reorganized and designated as the Commission on Aging.

Establishment of Hypertension Screening Clinics

The Department of Health and Environmental Control has established a network of Hypertension Screening and Treatment Clinics throughout the state to detect and treat hypertension (high blood pressure). This condition, often symptomless, occurs more than twice as often among people aged 65-80 than in the population as a whole.

Free Tuition for Elderly South Carolinians at State Educational Institutions

State-supported colleges, universities and technical schools may now permit South Carolina residents at least 65 years of age to attend classes on a space available basis without payment of tuition.

Adult Abuse and Protection Act

An Act has been enacted into law to prohibit the abuse, neglect or exploitation of a senile or developmentally disabled person and to provide protective services for such a person.

Retirement After 30 Years of Service

Members of the South Carolina State Retirement System may now retire at 65 years of age or after 30 years of service.

Removal of Reference to Age as a Qualification to Serve on a Jury

The South Carolina Code has been amended to eliminate a reference to age as a qualification to serve on a jury.

Creation of a Long-Term Care Division

A Long-Term Care Division has now been established within the S. C. Department of Mental Health and is under the direction of a deputy commissioner.

Allowance of Reciprocal Agreements Between States Regarding Retirement Income

South Carolina can now enter into a reciprocal agreement with another state to refrain from taxing retirement income.

Establishment of a Monetary Penalty System for Health Care Facilities

A monetary penalty system has now been established for violation of licensing standards in hospitals, nursing homes and intermediate care facilities.

Establishment of Licensing Authority for Adult Day Care Facilities

The licensing authority for adult day care facilities has now been established under the Department of Health and Environmental Control.

Establishment of the Community Education Advisory Council

The Community Education Advisory Council has now been established to promote and coordinate the utilization of school and other community facilities for the needs of the community.

Establishment of Retirement and Pre-Retirement Advisory Board

A Retirement and Pre-Retirement Advisory Board has been established to review retirement and pre-retirement programs and policies, propose recommendations and identify major issues for consideration. Two of the members of the eight-member Board shall be retired.

Exemption from Sales Tax on Prescription Drugs and Prosthetic Devices

In 1973, the General Assembly passed legislation to exempt those 65 years of age and older from paying tax on prescription drugs and prosthetic devices. This law was amended in 1974 to reduce the age to 50 and in 1976, tax on prescription drugs was repealed.

Half-Price Admission to Certain State Park Facilities

South Carolinians aged 65 or older are granted half-price admission to state park facilities for which a charge is customarily made (except cabin rentals).

Free Hunting and Fishing Licenses

Residents of South Carolina for three years who are 65 or older are eligible for free hunting or fishing licenses from the Department of Wildlife and Marine Resources.